Characterisation of extracellular redox enzyme concentrations in response to exercise in humans

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Abstract (249/ 250 Words)

Redox enzymes are ubiquitous proteins that modulate intracellular redox balance and can be secreted in response to cellular oxidative stress, potentially modulating systemic inflammation. Both aerobic and resistance exercise are known to cause acute systemic oxidative stress and inflammation; however, how redox enzyme concentrations alter in extracellular fluids following bouts of either type of exercise is unknown. Recreationally active, healthy males (n=26, age 28 ± 8 years) took part in either: 1) two separate energy-matched cycling bouts: one of moderate intensity (MOD) and a bout of high intensity interval exercise (HIIE) or 2) an eccentric exercise protocol. Alterations in plasma (study 1) and serum (study 2) peroxiredoxin (PRDX)-2, PRDX-4, superoxide dismutase-3 (SOD3), thioredoxin (TRX-1), TRX-reductase and Interleukin (IL)-6 were assessed before and at various timepoints after exercise. There was a significant increase in SOD3 (+1.5 ng/mL) and PRDX-4 (+5.9 ng/mL) concentration following HIIE only, peaking at 30 and 60min post-exercise respectively. TRX-R decreased immediately and 60 min following HIIE (-7.3 ng/mL) and MOD (-8.6 ng/mL) respectively. In non-resistance trained males, no significant changes in any of the redox enzymes were observed up to 48 hours following eccentric exercise. IL-6 concentration increased in response to all trials, however there was no significant relationship between absolute or exercise-induced changes in redox enzyme concentrations. These results collectively suggest that HIIE, but not MOD or eccentric exercise increase the extracellular concentration of PRDX-4 and SOD3. Exercise-induced changes in redox enzyme concentration do not appear to directly relate to systemic changes in IL-6 concentration.

Abbreviations: ANOVA: Analysis of Variance, BMI: Body Mass Index, CK: Creatine Kinase, ELISA: Enzyme Linked Immunosorbent Assay, EV: Extracellular Vesicle, H_2O_2: Hydrogen Peroxide, HIIE: High Intensity Interval Exercise, IL: Interleukin, IPAQ: International Physical Activity Questionnaire, LDH: Lactate Dehydrogenase, MOD: Moderate Intensity Exercise, NADH: reduced nicotinamide adenine dinucleotide, $ONOO^-$: Peroxynitrite, PBS: Phosphate Buffered Saline, PBSwC: Phosphate Buffered Saline Wash Casein, PRDX: Peroxiredoxin, ROS: Reactive oxygen species, SD: Standard deviation, SOD: Superoxide Dismutase, TLR: Toll-like Receptor, TRX: Thioredoxin, TRX-R: Thioredoxin-Reductase, VO_{2MAX}: Maximum oxygen consumption.

Introduction

It is well documented that acute exercise perturbs cellular reduction-oxidation (redox) balance through the increased production of reactive oxygen species (ROS) within actively contracting skeletal muscle [1], as well as other infiltrating cell types [2]. Evidence suggests that ROS such as hydrogen peroxide (H_2O_2) and peroxynitrite ($ONOO^-$) have important roles in facilitating muscle contractile activity [3] and regulating the expression of genes involved with metabolism and endogenous antioxidant protection [4,5]. Conversely, heightened levels of exercise-induced H_2O_2 at the expense of antioxidant defense systems can elicit oxidative stress, which may limit contractile function and promote fatigue [6]. Given this biphasic relationship, studies have previously evaluated alterations in redox balance in response to both aerobic and resistance type exercise. These studies have primarily focused on the quantification of distal markers in extracellular fluids, such as the oxidation biomolecules and/or activity of antioxidant enzymes in plasma [7], serum [8], saliva [9] and urine [10]; highlighting exercise duration [11], intensity [12] and muscle-damage [13] as factors governing greater increases. However, criticisms are commonly made with regards to the direct relationship of these markers with the redox state of active tissues during exercise [14]. Recent evidence has highlighted that intracellular redox enzymes, such as peroxiredoxin (PRDX) can be secreted from skeletal muscle myocytes [15] and immune cells [16] in response to increasing concentrations of H_2O_2 *in vitro*. Human studies are also beginning to provide strong evidence that plasma/ serum PRDX-2 and PRDX-4 concentrations serve as important biomarkers of intracellular redox state in the context of acute and chronic inflammatory conditions [16,17].

PRDXs are a major family of ubiquitous redox proteins, which modulate intracellular redox balance through a highly reactive cysteine thiolate group. The reaction rate of this cysteine is markedly greater than any other thiol-containing protein [18], allowing rapid regulation of cellular H_2O_2, with some evidence to suggest that this may facilitate muscle contraction [19]. PRDX's are therefore reliable footprints of intracellular redox state, with heightened oxidation of the PRDX cysteine indicative of oxidative stress [20]. Recent work has begun to explore changes in the PRDX catalytic cycle in blood cells isolated from humans before and after acute exercise [21–23]. In parallel with increases in soluble markers of inflammation (e.g. Interleukin (IL)-6 and CRP), an increase in the oxidation PRDX (i.e. dimer and over-oxidised states) has been reported following intensive cycling and running exercise [21,23]. To our knowledge, the extracellular concentration of PRDX has yet to be explored in the context of exercise in humans. Interestingly, PRDX-2 can be secreted in

tandem with its enzymatic reducing partners, thioredoxin (TRX-1) and thioredoxin reductase (TRX-R) [16,26]. TRX-1 and TRX-R are cysteine and selenium based-antioxidant enzymes respectively, with higher reduction potentials than PRDX, thus contributing towards maintaining the antioxidant function of PRDX. In addition, the enzyme superoxide dismutase 3 (SOD3) is an extracellular antioxidant released upon cellular stimulation, providing an immediate change in extracellular antioxidant capacity [26,27]. Given the emerging body of literature supporting a relationship between intracellular oxidative stress, redox enzyme secretion and soluble inflammatory markers, the quantification of PRDX-2, PRDX-4, TRX-1, TRX-R and SOD3 in extracellular fluids offers the potential for accurate assessment of changes in oxidative stress and inflammation after different types of exercise.

Based upon existing knowledge of the factors that can impact acute changes in exercise-induced oxidative stress, we sought to perform two experiments to understand how novel markers, such as PRDX-2, PRDX-4, TRX-1, TRX-R and SOD3 respond to acute exercise, and whether relationships exist between changes in inflammation. Specifically, we aimed to characterise how these markers would be impacted by aerobic exercise intensity and eccentric-based resistance exercise. We tested the hypothesis that both protocols would elicit an increase in the concentrations of redox enzymes within plasma/ serum after exercise; with higher exercise intensity causing a larger increase following aerobic exercise.

Methods

Participants

Healthy, untrained participants were recruited for two independent studies (Table 1) Participants in both studies completed the International Physical Activity Questionnaire (IPAQ), which addresses habitual levels of weekly physical activity. Participants gave their informed written consent and all studies were approved by the local Ethical Review Committee, in accordance with the Declaration of Helsinki, 2008. Participants were all non-smokers and had not taken any antioxidant vitamin supplements or anti-inflammatory drugs for 4 weeks prior to the laboratory visits. All participants were required to refrain from any strenuous physical activity, consumption of alcoholic beverages or caffeine for at least two days prior to the experimental sessions.

Experimental Sessions

The full workflow for this project is detailed in Figure 1. Experimental sessions took place in the morning (7.00 - 8.00 am start time) under stable climatic conditions (18 - 20°C and humidity between 45 – 55%) and following at least a 10-hour fast. After a period of rest, height (*Seca Alpha, Hamburg, Germany*) and mass *(Tanita, Tokyo, Japan)* were determined.

In study 1, participants first visited the laboratory for an assessment of cardiorespiratory fitness ($\dot{V}O_{2\,MAX}$) using a ramp test to exhaustion on an electromagnetically braked cycle ergometer (*Lode Excalibur Sport, Groningen, Netherlands*). The protocol involved commencing pedalling at 100 Watts, followed by fixed 30-Watt power increments every 4 minutes. Oxygen uptake was assessed continuously using a breath-by-breath system (*Oxycon Pro, Jaeger, Wuerzberg, Germany*) and heart rate monitored using a Polar Vantage heart rate monitor (*Polar, Kempele, Finland*). The test ended when the participant reached volitional exhaustion or when a plateau in oxygen consumption was observed with an increase in workload [28]. A final obtained value of rate of oxygen consumption was accepted as $\dot{V}O_{2\,MAX}$ and expressed relative to body weight ($mL.kg^{-1}min^{-1}$). At least one week later, participants then undertook the first of two energy and time-matched cycling trials in a randomised order, at least one week apart: a moderate bout of steady-state cycling at 60% $\dot{V}O_{2\,MAX}$ for 58 minutes (MOD) and a bout of high intensity interval exercise (HIIE), consisting of 10 x 4-minute intervals at 85% $\dot{V}O_{2\,MAX}$, with 2-minute rest intervals. In both studies, oxygen uptake was assessed continuously to maintain target $\dot{V}O_2$ and equal energy expenditure between MOD and HIIE (study 1). Rating of Perceived Exertion was assessed throughout both trials.

In study 2 (n = 17), non-resistance trained males undertook a muscle-damaging eccentric exercise protocol adapted from a previous study by Alemany et al [29]. The eccentric muscle damage protocol was performed on a Humac Norm dynamometer (CSMI, Massachusetts, USA). The dynamometer lever arm was programmed to flex the participant's knee from a start position of 10° of flexion to 90° of flexion, thus allowing a range of motion of 80°. The participants began with their leg at the start position and were asked to maximally contract their quadriceps against a resistance while the lever arm moved to the finish position (90° knee flexion). Once at the finish position they were advised to relax their leg and the dynamometer moved them back to the start position to avoid a concentric contraction being performed. The lever arm moved at a set speed of $60°\cdot s^{-1}$. The bout consisted of 20 sets of 10 repetitions with each set being separated by 1 minutes rest. Visual feedback and verbal encouragement was provided to all participants to maximise torque output for each

contraction. Following the muscle damaging protocol, all participants completed another maximal quadricep contraction.

Blood sampling and Plasma Isolation

For both studies, a catheter (*Appleton Woods, Birmingham, UK)* was inserted into the antecubital vein of the arm prior to exercise to obtain a baseline blood sample after thirty minutes of rest (Pre). The catheter was continually kept clear with isotonic saline solution (0.9% sodium chloride). As indicated in Figure 1, blood samples were then taken immediately, 30 minutes and 60 minutes after both HIIE and MOD (Study 1 – Pre, Post+0, Post+30 and Post+60) and post muscle damage, post-performance, 3 hours and 48 hours after the eccentric exercise protocol (Study 2 – Pre, Post-MD, Post-Per, Post+3hr and Post+48hr). The post+48 hr (Study 2) blood sample was taken via venepuncture. At each time point, 12 mL of blood was drawn into vacutainer tubes containing either potassium ethylene diaminetetraacetic acid in study 1 (*Becton, Dickson & Company, Oxford, UK*) or no anticoagulant in study 2. In study 1, whole blood was centrifuged at 1525g for 15 minutes, at room temperature. In study 2, whole blood was allowed to clot at room temperature for 20 mins and then centrifuged at 1500g for 15 minutes. The resulting plasma (study 1) and serum (study 2) were aliquoted and frozen at -80°C for future analysis of redox enzymes and IL-6. Finger prick blood samples were obtained to determine lactate (study 1) and creatine kinase (CK)/ lactate dehydrogenase (LDH) (study 2) concentrations.

Analytical Procedures

PRDX-2, PRDX-4. TRX-1, TRX-R and SOD3 ELISAs

ELISAs for the detection of PRDX-2, PRDX-4, TRX, TRX-R and SOD3 were developed in-house. Commercially available antigens and antibodies (i.e. PRDX-2. PRDX-4, TRX and TRX-R) were purchased from either *Abcam*, Cambridge, UK (ab) or *Sigma Aldrich*, Dorset, UK (SRP). The human SOD3 antigen and rabbit antiserum directed against human SOD3 were developed as previously described [26,30]. Plasma or serum and standards (100 μL) were loaded onto individual wells of an ELISA plate (Thermo Scientific F8 polysorp immune wells) and protein left to bind overnight at 4 ºC. Wells were then pre-washed with PBS wash buffer, supplemented with 0.1% casein (PBSwC, 200 μL) and then blocked with 1% casein in PBS (200 μL) for 30 minutes at room temperature, with gentle agitation. Anti-human rabbit antibodies for PRDX-2 (ab133481, 1:2000), PRDX-4 (ab59542, 1:2000) and SOD3 (in-house, 1:2000), and anti-human mouse antibodies for TRX-1 (ab16965, 1:8000) and TRX-R

(ab16847, 1:1000) were then added to each well, diluted in PBSwC for 45 minutes at room temperature. Following this, 100 μL of anti-rabbit (1:5000) or anti-mouse (1:500) IgG Biotin antibodies in PBSwC, and streptavidin-horseradish peroxidase (1:2000 in PBSwC) were added separately to each well, both for 45 minutes, with gentle agitation. Between all stages, all wells were washed three times with PBSwC. Finally, 100 μL of 3,3',5,5'-tetramethylbenzidine (10ug) was added per well, and the plate left to develop in the dark for 15-25 minutes. Stop solution (1.5mM H_2SO_4, 50 μL) was then added to each well and absorption at 450nm subsequently evaluated by using a plate reader (Multiskan Ascent, Thermo Labsystems). Concentration of each antigen was then determined by comparing absorbance values of recombinant PRDX-2 (ab167977, *Abcam*), PRDX-4 (ab93947, *Abcam*), TRX-1 (ab51064, *Abcam*), TRX-R (SRP6081, *Sigma Aldrich*) and SOD3 (in-house) proteins (0-50 ng/mL). ELISA validation experiments showed no cross-reactivity of the PRDX-2, PRDX-4, TRX-1, TRX-R and SOD3 antibodies with the respective antigens, nor with serum albumin. All values were adjusted for plasma volume, according to previous methods [31].

Other Analyses

In both studies, a cytometric bead array was used to quantify plasma (study 1) and serum (study 2) IL-6 concentrations on a BD C6 Accuri Flow Cytometer (*BD Biosciences, Berkshire*). In study 1, blood lactate and glucose concentrations were determined after 4 min of exercise and then every 6 min thereafter (i.e. end of each HIIE interval) using an automated lactate and glucose analyser (Biosen C-Line Clinic, EKF-diagnostic GmbH, *Barleben, Germany*) to verify intensity-dependent differences between each protocol. In study 2, serum CK and LDH concentrations were determined to monitor muscle damage using an automated ABX Pentra 400 system (*Horiba UK Ltd, UK*). Haematocrit and haemoglobin concentrations were used to ascertain plasma volume changes and make appropriate adjustments in plasma redox enzyme and IL-6 concentrations (Beckman Coulter, *London, UK*).

Statistical Analysis

The Shapiro Wilk test was used to test for normality in scale data at all time points. Differences between participant characteristics and the physiological responses to exercise in both studies were assessed using unpaired samples T-tests or non-parametric Mann-Whitney U Tests. The influence of exercise on plasma/ serum PRDX-2, PRDX-4, SOD3, TRX-1, TRX-R and IL-6 concentration was assessed over time by repeated-measures analysis of

variance (ANOVA) or non-parametric Wilcoxon signed rank tests, depending variable normality. Post hoc analysis of any significant effect of time or interaction effect (study 1; Group*Time) was performed by a test of simple effects by pairwise comparisons, with Bonferroni correction. Effect sizes for main effects and interaction effects of ANOVA are presented as partial eta[2] (η^2_p), using Cohen's definition of η^2_p of 0.01, 0.06 and 0.14 for 'small', 'medium' and 'large' effects respectively [32]. All values are presented as means ± standard deviation or error (indicated throughout manuscript). Statistical significance was accepted at the $p < .05$ level. Statistical analyses were performed using SPSS (*PASW Statistics, release 23.0, SPSS Inc., Chicago, IL, USA*).

Results

For each of the respective studies, participants completed the continuous moderate intensity, HIIE and eccentric exercise protocols. There was no significant difference in age or BMI between the participants taking part in the two studies, Participants in study 1 ($p = 0.004$) had significantly higher self-reported physical activity than in study 2.

Effects of aerobic exercise on physiological responses and blood markers

For study 1, the physiological responses during each exercise bout are reported in Table 2. Peak $\dot{V}O_2$ and RPE were significantly greater in HIIE compared to MOD ($p < 0.00001$), but there were no statistically significant differences in mean $\dot{V}O_2$ and energy expenditure. Whole blood lactate and glucose data are reported in Table 2. Average lactate concentration was significantly higher during HIIE than MOD ($p < 0.0001$), but there was no significant difference in average glucose concentration between trials.

Effects of eccentric exercise on muscle damage markers

In study 2, there was a stepwise increase (Post+48hr > Post+3hr > Post-Per > Post MD > Pre) in serum CK over time, with the concentration peaking above Pre at Post+48hr (Units/ L: Pre: 147.6 ± 27.1 and Post+48hr: 575.9 ± 290.8; $p > 0.001$). Serum LDH concentration was elevated above Pre at all post-exercise timepoints (Units/ L: Pre: 254.9 ± 130.6 and peak at Post+48hr: 299.9 ± 165.2; $p < 0.05$), also increasing Post+3hr, relative to Post-MD (Units/ L: Post-MD: 274.1 ± 77.1 & Post+3hr: 290.3 ± 77.8; $p = 0.011$).

Effects of aerobic and eccentric exercise on IL-6 concentration

IL-6 data is presented in Figure 3. In study 1, plasma IL-6 increased in both trials (Time effect: $F(3) = 15.5$, $p < 0.0001$, $\eta^2 = 0.66$), being elevated above resting values, both immediately ($p = 0.004$) and Post+30 ($p = 0.002$), but not Post+60 (Figure 3A). The magnitude of this increase was significantly greater Post-Ex in HIIE ($p = 0.031$), than MOD (Time x Condition effect: $F(3) = 7.0$, $p < 0.001$, $\eta^2 = 0.47$). IL-6 concentration decreased Post+30 ($p = 0.004$) and Post+60 ($p = 0.007$), relative to Post+0, and Post+60, relative to Post+30 ($p = 0.026$) in HIIE only. In study 2 (Figure 3B), IL-6 concentration was significantly higher at all timepoints up to three hours, but not 48 hours after exercise, relative to Pre (Time effect: $F(4) = 14.3$, $p < 0.0001$, $\eta^2 = 0.30$).

Effects of aerobic exercise on PRDX-2, PRDX-4, TRX-1, TRX-R and SOD3 concentration

No differences were observed in resting concentrations of PRDX-2, PRDX-4, TRX-1, TRX-R or SOD3 when quantified in plasma and serum across all trials. Changes in plasma PRDX-2, PRDX-4, TRX-1, TRX-R and SOD3 in response to MOD and HIIE are reported in Figure 2A. There was a significant increase in plasma SOD3 (Trial x Time Effect: $F(3,1) = 5.3$, $p = 0.028$, $\eta^2 = 0.31$) and PRDX-4 following HIIE only (non-parametric tests: all $p < 0.05$). SOD3 concentration was elevated above pre-exercise values at all post-HIIE timepoints, peaking at Post+0 ($p = 0.015$) and Post+30 ($p = 0.013$), but only significantly higher than MOD at Post+30 ($p = 0.05$). Plasma SOD3 concentration decreased relative to Post+30 at Post+60 ($p = 0.013$). Relative to Pre, PRDX-4 concentration increased at Post+30 ($p = 0.015$) and Post+60 ($p = 0.008$) following HIIE, with PRDX-4 concentration higher at all post-exercise timepoints compared with MOD ($p < 0.038$). There was a significant decrease in plasma TRX-R concentration in both MOD and HIIE. Relative to Pre, TRX-R significantly decreased at Post+0 in HIIE only ($p = 0.021$), with values significantly less than MOD ($p = 0.011$). Following MOD, TRX-R was significantly lower at Post+60, relative to all timepoints (all $p < 0.038$). There were no statistically significant changes in PRDX-2 and TRX-1 concentration over time in either trial; however, TRX-1 concentration was significantly higher in HIIE than MOD Post+60 only ($p = 0.021$).

Effects of eccentric exercise on PRDX-2, PRDX-4, TRX-1, TRX-R and SOD3 concentration

Serum redox enzyme concentration changes in response to an eccentric exercise protocol are presented in Figure 2B. A trend was observed for a decrease in PRDX-2 concentration Post Performance (-1.12 ng/mL), however this did not reach statistical

significance (Time effect: F (4) = 2.3, p = 0.065, η^2 = 0.13). Similarly, no significant changes were noted in PRDX-4, TRX-R or SOD3 up to 48 hours following eccentric exercise. A significant increase in TRX-1 was shown Post+48hr, relative to Post-Per (p = 0.039), but not Pre (p = 0.309).

Discussion

The current results have characterised the kinetic responses of endogenous redox enzymes within the extracellular environment after exercise for the first time. The primary finding from this investigation was that high intensity interval cycling (study 1) caused an increase in the concentrations of plasma PRDX-4 and SOD3 in healthy, untrained males. Plasma TRX-R levels also decreased within one hour of both moderate and high intensity cycling exercise. These responses were not observed following muscle-damaging exercise in non-resistance trained males (study 2).

The current data highlights modality and exercise-intensity specific increases in two abundant redox enzymes. In response to aerobic-based exercise, PRDX-4, but not PRDX-2 concentration increased thirty minutes following HIIE and remained elevated until Post+60. The secretory pathways of PRDX's are isoform specific, with endoplasmic reticulum (ER, i.e. PRDX-4) and cytosolic (i.e. PRDX-2) resident isoforms released via classical and non-classical secretory pathways respectively [33]. The current data therefore suggests that exercise may activate the ER-golgi pathway to secrete PRDX-4 in an intensity-dependent manner. SOD3, which is also released via this pathway, increased immediately following HIIE, with levels tailoring off Post+60, relative to Post+30. SOD3 is an antioxidant enzyme typically contained within membrane-associated vesicles, specifically secreted to modulate superoxide anions in the extracellular environment either on parent or target cells [26,27]. Due to its membrane proximity, SOD3 can be rapidly secreted into the extracellular environment in response to cellular oxidative stress [26,27]. This may explain the difference in timecourse when comparing SOD3 (i.e. Post+0) and PRDX-4 (i.e. Post+30) responses following HIIE. This may also be reflective of differential secretion rates of SOD3 and PRDX-4 from various tissues during and following exercise. Both proteins are expressed in skeletal muscle [34], a highly redox active tissue [35]; however, PRDX-4 is primarily located in pancreas, liver and heart [36], whereas SOD3 is expressed in the heart and vasculature tissue [37]. The association with the vasculature may explain the more rapid increase in plasma SOD3 concentration

following HIIE. Aside from these increases, a modest decrease was observed in plasma TRX-R after both MOD and HIIE (study 1), with this change being much more rapid in HIIE (Post+0), compared to MOD (Post+60). The mechanisms driving a decrease in TRX-R after exercise are unclear at present. The decrease may represent transient homeostatic fluctuations involving uptake of redox enzymes by neighboring cells and tissues, perhaps to regulate intracellular redox balance [43].

A finding that was in contrast to our hypothesis was that muscle damaging eccentric exercise did not induce an increase in the extracellular concentrations of redox enzymes. The measurement of redox enzymes in plasma and serum is an emerging area of biomedical research, particularly in the context of acute [38] and chronic [39,40] inflammatory conditions, where PRDXs and TRX-1 have been shown to enhance cytokine and chemokine production [41,42]. The participants in both studies were relatively inactive, with participants in study 2 in particular, reporting significantly lower levels of habitual physical activity (Table 2) and being unaccustomed to eccentric exercise. Unaccustomed eccentric exercise induces significant amounts of acute muscle damage and inflammation [44], as demonstrated by the stepwise increases in CK and LDH concentrations up to 48 hours following our protocol, and IL-6 up to 3 hours post-exercise (Figure 3B). It must be acknowledged that only selective timepoints were measured following the protocol, and perhaps the secretion of redox enzymes occurs between 3- and 48-hours post-exercise. Nevertheless, this study has highlighted for the first time that redox enzyme concentrations do not match that of established markers of muscle damage and inflammation when measured in serum samples following a muscle damaging exercise bout. In response to aerobic-based exercise, we have recently demonstrated a positive association between intracellular Peroxiredoxin (I-IV) over-oxidation in immune cells and plasma IL-6 concentration [23]. In the current study, IL-6 concentration increased in an intensity-dependent manner (HIIE > MOD) following aerobic exercise (Figure 3A); however, there were no statistically significant relationships between absolute or exercise-induced changes in PRDX-4 and SOD3 with IL-6. The observations across both studies therefore suggest no relationship between that IL-6 and redox enzymes after exercise. A larger sample size may be needed to adequately address these associations and support the previously documented relationship between plasma/ serum redox enzymes and soluble inflammatory markers [16,17].

The results of the current investigation demonstrate clear differences in the changes in SOD3, TRX-R and PRDX-4 following aerobic vs. anaerobic exercise. With regards to

PRDX-2 and TRX-1, no changes were observed following aerobic or anaerobic exercise. Both PRDX-2 and TRX-1 are cytosolic redox enzymes that contain no N-terminal signal peptide for secretion and thus are released via non-classical pathways, associated with extracellular vesicles (EV's), such as exosomes and nanoparticles [45]. PRDX-2 and TRX-1 are detectable in plasma/ serum samples through their association with the exofacial surface of the EV membrane [46,47]; however, their protein levels may be higher due to protein contained within the EV's. This protein would not be detectable by antibodies when enclosed within the lipid membrane during ELISA quantification, as previously shown [48]. Indeed, recent evidence has highlighted that a series of leaderless redox enzymes (i,e, PRDX-1, PRDX-2, PRDX-5, PRDX-6, TRX-1, SOD1 and SOD2) are secreted in EV's via a non-classical route following exposure to stress, with classically secreted SOD3, TRX-R and PRDX-4 not detectable within EV's [49]. This may explain why plasma/ serum PRDX-2 and TRX-1 concentration in samples did not significantly change following both muscle-damaging and aerobic exercise. It must be noted that TRX-1 concentration was significantly higher 48 hours after the eccentric exercise protocol, relative to Post-MD (study 2) and also significantly higher at Post+60 in HIIE, compared to MOD (study 1). These findings again underpin intensity-dependent differences, despite in both cases, levels not being higher than pre-exercise values. In response to a far more extreme bout of exercise, Marumoto *et al*, (2010) reported a marked increase in plasma volume adjusted TRX-1 levels (17.9 ± 1.2 ng/mL at baseline to 70.1 ± 6.9 ng/mL) after a 2-day 130km ultra-endurance marathon [50]; however, these exercise bouts were substantially different in nature and thus hard to directly compare. Further work is needed to clarify whether TRX-1 and PRDX-2 protein levels alter within EVs after conventional bouts (i.e. not ultra-endurance) of muscle-damaging and aerobic-based exercise.

This study has quantified the responses of antioxidant enzymes in the extracellular environment following acute exercise in age and BMI matched individuals from two independent exercise studies (Table 1). We must also acknowledge that quantification of redox enzymes and IL-6 was undertaken in both plasma (study 1) and serum (study 2), however; there were no differences in any of these proteins when quantified in pre-exercise samples (*data not shown*).

Perspectives

The current results provide valuable information on the physiological effects that exercise can have on extracellular redox enzyme concentrations in blood. Building on previous work, which has demonstrated that some redox enzymes (i.e. PRDX and TRX) are sensitive to exercise-induced oxidative stress within blood cells (i.e. leukocytes [51] and erythrocytes [52]), we provide preliminary evidence to suggest that SOD3 and PRDX4 may be secreted following single sessions of high intensity cycling. Given the emerging link between these proteins and aspects of the inflammatory response in clinical settings [42], and the possible association with exercise intensity shown herein, we suggest that these markers are worthy of future investigation in the discipline of sport and exercise medicine (e.g. biomarkers of overtraining).

Conclusion

The results of the present study have highlighted that plasma SOD3 and PRDX-4 concentration increased in response to acute exercise. Importantly, the secretion of these proteins appears to be intensity and modality dependent, with increases only observed in response to high intensity aerobic cycling in untrained individuals. A decrease in TRX-R was also noted following different aerobic exercise bouts, with exercise intensity driving a more rapid decrease in TRX-R. Future research is required to pinpoint the precise mechanisms governing the secretion and uptake of redox enzymes, and their role in regulating redox balance between tissues after exercise.

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Conflict of Interest

None of the authors declare a conflict of interest.

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Tables

Table 1. Demographics for participants in studies 1 and 2.

	Energy-matched Trials (study 1)	**Eccentric Exercise (study 2)**	**Statistical Analysis**
Number of Participants	9	17	n/a
Age (years)	29 ± 5	25 ± 9	P = NS
Body Mass Index ($kg/m^{2)}$	24.2 ± 3.4	25.3 ± 4.1	P = NS
IPAQ (METs-min/week)	6683 ± 3835*****	2540 ± 2022	$^{+}$P = 0.005 $^{+}$P = 0.004
Watt Max (Watt/kg)	3.4 ± 0.5		n/a
$\dot{V}O_{2\ \mathbf{MAX}}$ **($mL.kg^{-1}.min^{-1}$)**	44.5 ± 6.4		n/a

Grey boxes indicate missing data.

* Indicates significant difference in comparison to study 2: *P < 0.05, **P < 0.001.

NS P > 0.05.

Table 2. Physiological response to aerobic-based exercise (study 1).

	Energy-matched Cycling Trials (Study 1)		**Statistical Analysis**
Trial	Continuous cycling for 58 min, predicted 60% $\dot{V}O_{2\ MAX}$ (MOD)	10 x 4 min cycling intervals, predicted 85% $\dot{V}O_{2\ MAX}$ (2 min rest intervals. Total time = 58 min, HIIE)	--
Mean $\dot{V}O_{2\ MAX}$ (%)	56.5 ± 2.6	58.9 ± 4.3	P = NS
Energy Expenditure (kJ)	2077 ± 340	2072 ± 339	P = NS
Average RPE	12 ± 1	16 ± 1***	***P < 0.0001
Mean Blood Lactate (mmol/L)	1.9 ± 0.6	6.8 ± 1.4	***P < 0.0001
Mean Blood Glucose (mmol/L)	3.9 ± 0.3	4.5 ± 0.6	P = NS

* Indicates a significant difference between MOD and HIIE: *** P < 0.0001.

NS P > 0.05.

Figures

Figure 1: Schematic of the two exercise studies. Dark lines represent the exercise session, with lighter lines indicating pre- and post-exercise resting periods. Gaps between dark lines indicate the rest periods during the HIIE trial. Blood samples taken for each study are indicated as arrows.

Figure 2: Changes in plasma redox protein concentration in response to two energy-matched cycling bouts (A) - moderate steady state (MOD - black bars) and high intensity interval exercise (HIIE – white bars) and an eccentric exercise protocol (B): PRDX-2, PRDX-4, TRX-1, TRX-R and SOD3. Values are means ± standard error. * indicates significant differences relative to Pre: * $p<.05$. # indicates a significant difference relative to Post+0: # $p<.05$. $ indicates a significant difference relative to Post+30: $ $p<.05$. + indicates a significant difference between MOD and HIIE: + $p<.05$.

Figure 3: Changes in plasma IL-6 in response to two energy-matched cycling bouts: moderate steady state (MOD - black bars) and high interval exercise (HIIE – white bars). Values are means ± standard error. * indicates significant differences relative to Pre: * $p<.05$; ** $p<.001$. # indicates a significant difference relative to Post+0: # $p<.05$. $ indicates a significant difference relative to Post+30: $ $p<.05$. + indicates a significant difference between MOD and HIIE: + $p<.05$.